

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

42870

STATE FILE NUMBER

FILED NOV 22 1957

Registration District No. **317**

Primary Registration District No. **541**

Registrar's No. **2804**

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| 1. PLACE OF DEATH a. COUNTY St. Louis b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Co. Hosp. Length of stay in lb DOA | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis c. CITY OR TOWN Brentwood 4511 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 8720 Radley Ct. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First JeMary Middle Jennifer Last Heib | | | | 4. DATE OF DEATH Month Nov. Day 9th Year 1957 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 29th 1955 | | 9. AGE (In years last birthday) 2 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Conrad Heib | | | | 14. MOTHER'S MAIDEN NAME Arlene Florreich | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Conrad Heib Address Above | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LA RYNGO TRACHEO BRONCHITIS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) 501X DUE TO (c) _____ PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH -2 hr | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | | | | | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____ | | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | |
| 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____ | | | 20f. CITY, TOWN, OR LOCATION _____ | | COUNTY _____ STATE _____ | | | | |
| 21. I attended the deceased from 11-8-57 to 11-9-57 and last saw her him alive on 11-9-57 Death occurred at 10:24 A m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE Lea Ann W. (Degree or title) MD | | | | 22b. ADDRESS ST LOUIS 19th 337 W. LOCKWOOD AVE | | 22c. DATE SIGNED 11-12-57 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-12-57 | | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem. | | 23d. LOCATION (City, town, or county) St. Louis Co. Mo. (State) _____ | | | |
| 24. FUNERAL DIRECTOR JAY E. SMITH, Maplewood, Mo. ADDRESS _____ | | | | 25. DATE RECD. BY LOCAL REG. 11-12-57 | | 26. REGISTRAR'S SIGNATURE Hebert R. Sommers | | | |

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Special permission required by 193-140 MoRS 1949.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed

Licensed Embalmer No. 415

P. O. Address

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.

If this body is not embalmed, fact should be so stated above.